General Assembly

Amendment

February Session, 2022

LCO No. **5600**

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Offered by:
REP. WOOD K., 29th Dist.

To: Subst. House Bill No. **5042** File No. 56 Cal. No. 85

"AN ACT CONCERNING HEALTH CARE COST GROWTH."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 19a-754a of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, as amended by this act, with the powers and duties therein prescribed.

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive

health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

(3) Directing and overseeing the State Innovation Model Initiative and related successor initiatives;

(4) (A) Coordinating the state's health information technology initiatives, (B) seeking funding for and overseeing the planning, implementation and development of policies and procedures for the administration of the all-payer claims database program established under section 19a-775a, (C) establishing and maintaining a consumer health information Internet web site under section 19a-755b, and (D) designating an unclassified individual from the office to perform the duties of a health information technology officer as set forth in sections 17b-59f and 17b-59g;

(5) Directing and overseeing the Health Systems Planning Unit established under section 19a-612 and all of its duties and responsibilities as set forth in chapter 368z;

(6) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies; **[**and**]**

(7) (A) Administering the Covered Connecticut program established under section 19a-754c in consultation with the Commissioner of Social Services, Insurance Commissioner and Connecticut Health Insurance Exchange, and (B) consulting with the Commissioner of Social Services and Insurance Commissioner for the purposes set forth in section 17b-312; **[**.**]** and

(8) (A) Setting an annual health care cost growth benchmark and primary care spending target pursuant to section 3 of this act, (B) developing and adopting health care quality benchmarks pursuant to section 3 of this act, (C) developing strategies, in consultation with stakeholders, to meet such benchmarks and targets developed pursuant to section 3 of this act, (D) enhancing the transparency of provider entities, as defined in subdivision (13) of section 2 of this act, (E) monitoring the development of accountable care organizations and patient-centered medical homes in the state, and (F) monitoring the adoption of alternative payment methodologies in the state.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081, relating to the administration of the all-payer claims database pursuant to section 19a-755a; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725, and (C) (i) appointment of the health information technology officer, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59f and 17b-59g.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 2. (NEW) (*Effective from passage*) For the purposes of this section and sections 3 to 7, inclusive, of this act:

(1) "Drug manufacturer" means the manufacturer of a drug that is: (A) Included in the information and data submitted by a health carrier

pursuant to section 38a-479qqq of the general statutes, (B) studied or listed pursuant to subsection (c) or (d) of section 19a-754b of the general statutes, or (C) in a therapeutic class of drugs that the executive director determines, through public or private reports, has had a substantial impact on prescription drug expenditures, net of rebates, as a percentage of total health care expenditures;

(2) "Executive director" means the executive director of the Office of Health Strategy;

(3) "Health care cost growth benchmark" means the annual benchmark established pursuant to section 3 of this act;

(4) "Health care quality benchmark" means an annual benchmark established pursuant to section 3 of this act;

(5) "Health care provider" has the same meaning as provided in subdivision (1) of subsection (a) of section 19a-17b of the general statutes;

(6) "Net cost of private health insurance" means the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses;

(7) "Office" means the Office of Health Strategy established under section 19a-754a of the general statutes, as amended by this act;

(8) "Other entity" means a drug manufacturer, pharmacy benefits manager or other health care provider that is not considered a provider entity;

(9) "Payer" means a payer, including Medicaid, Medicare and governmental and nongovernment health plans, and includes any organization acting as payer that is a subsidiary, affiliate or business owned or controlled by a payer that, during a given calendar year, pays health care providers for health care services or pharmacies or provider

entities for prescription drugs designated by the executive director;

(10) "Performance year" means the most recent calendar year for which data were submitted for the applicable health care cost growth benchmark, primary care spending target or health care quality benchmark;

(11) "Pharmacy benefits manager" has the same meaning as provided in subdivision (10) of section 38a-479ooo of the general statutes;

(12) "Primary care spending target" means the annual target established pursuant to section 3 of this act;

(13) "Provider entity" means an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract;

(14) "Potential gross state product" means a forecasted measure of the economy that equals the sum of the (A) expected growth in national labor force productivity, (B) expected growth in the state's labor force, and (C) expected national inflation, minus the expected state population growth;

(15) "Total health care expenditures" means the sum of all health care expenditures in this state from public and private sources for a given calendar year, including: (A) All claims-based spending paid to providers, net of pharmacy rebates, (B) all patient cost-sharing amounts, and (C) the net cost of private health insurance; and

(16) "Total medical expense" means the total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of (A) all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates, (B) all nonclaims payments for such year,

including, but not limited to, incentive payments and care coordination payments, and (C) all patient cost-sharing amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state.

Sec. 3. (NEW) (*Effective from passage*) (a) Not later than July 1, 2022, the executive director shall publish (1) the health care cost growth benchmarks and annual primary care spending targets as a percentage of total medical expenses for the calendar years 2021 to 2025, inclusive, and (2) the annual health care quality benchmarks for the calendar years 2022 to 2025, inclusive, on the office's Internet web site.

(b) (1) (A) Not later than July 1, 2025, and every five years thereafter, the executive director shall develop and adopt annual health care cost growth benchmarks and annual primary care spending targets for the succeeding five calendar years for provider entities and payers.

(B) In developing the health care cost growth benchmarks and primary care spending targets pursuant to this subdivision, the executive director shall consider (i) any historical and forecasted changes in median income for individuals in the state and the growth rate of potential gross state product, (ii) the rate of inflation, and (iii) the most recent report prepared by the executive director pursuant to subsection (b) of section 4 of this act.

(C) (i) The executive director shall hold at least one informational public hearing prior to adopting the health care cost growth benchmarks and primary care spending targets for each succeeding five-year period described in this subdivision. The executive director may hold informational public hearings concerning any annual health care cost growth benchmark and primary care spending target set pursuant to subsection (a) or subdivision (1) of subsection (b) of this section. Such informational public hearings shall be held at a time and place designated by the executive director in a notice prominently posted by the executive director on the office's Internet web site and in a form and manner prescribed by the executive director. The executive director

shall make available on the office's Internet web site a summary of any such informational public hearing and include the executive director's recommendations, if any, to modify or not to modify any such annual benchmark or target.

(ii) If the executive director determines, after any informational public hearing held pursuant to this subparagraph, that a modification to any health care cost growth benchmark or annual primary care spending target is, in the executive director's discretion, reasonably warranted, the executive director may modify such benchmark or target.

(iii) The executive director shall annually (I) review the current and projected rate of inflation, and (II) include on the office's Internet web site the executive director's findings of such review, including the reasons for making or not making a modification to any applicable health care cost growth benchmark. If the executive director determines that the rate of inflation requires modification of any health care cost growth benchmark adopted under this section, the executive director may modify such benchmark. In such event, the executive director shall not be required to hold an informational public hearing concerning such modified health care cost growth benchmark.

(D) The executive director shall post each adopted health care cost growth benchmark and annual primary care spending target on the office's Internet web site.

(2) (A) Not later than July 1, 2025, and every five years thereafter, the executive director shall develop and adopt annual health care quality benchmarks for the succeeding five calendar years for provider entities and payers.

(B) In developing annual health care quality benchmarks pursuant to this subdivision, the executive director shall consider (i) quality measures endorsed by nationally recognized organizations, including, but not limited to, the National Quality Forum, the National Committee for Quality Assurance, the Centers for Medicare and Medicaid Services,

the Centers for Disease Control, the Joint Commission and expert organizations that develop health equity measures, and (ii) measures that: (I) Concern health outcomes, overutilization, underutilization and patient safety, (II) meet standards of patient-centeredness and ensure consideration of differences in preferences and clinical characteristics within patient subpopulations, and (III) concern community health or population health.

(C) (i) The executive director shall hold at least one informational public hearing prior to adopting the health care quality benchmarks for each succeeding five-year period described in this subdivision. The executive director may hold informational public hearings concerning the quality measures the executive director proposes to adopt as health care quality benchmarks. Such informational public hearings shall be held at a time and place designated by the executive director in a notice prominently posted by the executive director on the office's Internet web site and in a form and manner prescribed by the executive director. The executive director shall make available on the office's Internet web site a summary of any such informational public hearing and include the executive director's recommendations, if any, to modify or not modify any such health care quality benchmark.

(ii) If the executive director determines, after any informational public hearing held pursuant to this subparagraph, that modifications to any health care quality benchmarks are, in the executive director's discretion, reasonably warranted, the executive director may modify such quality benchmarks. The executive director shall not be required to hold an additional informational public hearing concerning such modified quality benchmarks.

(D) The executive director shall post each adopted health care quality benchmark on the office's Internet web site.

(c) The executive director may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and

other experts and consultants.

Sec. 4. (NEW) (*Effective from passage*) (a) Not later than August 15, 2022, and annually thereafter, each payer shall report to the executive director, in a form and manner prescribed by the executive director, for the preceding or prior years, if the executive director so requests based on material changes to data previously submitted, aggregated data, including aggregated self-funded data as applicable, necessary for the executive director to calculate total health care expenditures, primary care spending as a percentage of total medical expenses and net cost of private health insurance. Each payer shall also disclose, as requested by the executive director, payer data required for adjusting total medical expense calculations to reflect changes in the patient population.

(b) Not later than March 31, 2023, and annually thereafter, the executive director shall prepare and post on the office's Internet web site, a report concerning the total health care expenditures utilizing the total aggregate medical expenses reported by payers pursuant to subsection (a) of this section, including, but not limited to, a breakdown of such population-adjusted total medical expenses by payer and provider entities. The report may include, but shall not be limited to, information regarding the following:

(1) Trends in major service category spending;

(2) Primary care spending as a percentage of total medical expenses;

(3) The net cost of private health insurance by payer by market segment, including individual, small group, large group, self-insured, student and Medicare Advantage markets; and

(4) Any other factors the executive director deems relevant to providing context on such data, which shall include, but not be limited to, the following factors: (A) The impact of the rate of inflation and rate of medical inflation; (B) impacts, if any, on access to care; and (C) responses to public health crises or similar emergencies.

(c) The executive director shall annually submit a request to the federal Centers for Medicare and Medicaid Services for the unadjusted total medical expenses of Connecticut residents.

(d) Not later than August 15, 2023, and annually thereafter, each payer or provider entity shall report to the executive director in a form and manner prescribed by the executive director, for the preceding year, and for prior years if the executive director so requests based on material changes to data previously submitted, on the health care quality benchmarks adopted pursuant to section 3 of this act.

(e) Not later than March 31, 2024, and annually thereafter, the executive director shall prepare and post on the office's Internet web site, a report concerning health care quality benchmarks reported by payers and provider entities pursuant to subsection (d) of this section.

(f) The executive director may enter into such contractual agreements as may be necessary to carry out the purposes of this section, including, but not limited to, contractual agreements with actuarial, economic and other experts and consultants.

Sec. 5. (NEW) (*Effective from passage*) (a) (1) For each calendar year, beginning on January 1, 2023, the executive director shall, if the payer or provider entity subject to the cost growth benchmark or primary care spending target so requests, meet with such payer or provider entity to review and validate the total medical expenses data collected pursuant to section 4 of this act for such payer or provider entity. The executive director shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year as set forth in section 4 of this act. The executive director shall identify, not later than May first of such calendar year, each payer or provider entity that exceeded the health care cost growth benchmark or failed to meet the primary care spending target for the performance year.

(2) For each calendar year beginning on or after January 1, 2024, the executive director shall, if the payer or provider entity subject to the health care quality benchmarks for the performance year so requests, meet with such payer or provider entity to review and validate the quality data collected pursuant to section 4 of this act for such payer or provider entity. The executive director shall review information provided by the payer or provider entity and, if deemed necessary, amend findings for such payer or provider prior to the identification of payer or provider entities that exceeded the health care quality benchmark as set forth in section 4 of this act. The executive director shall identify, not later than May first of such calendar year, each payer or provider entity that exceeded the health care quality benchmark for the performance year.

(3) Not later than thirty days after the executive director identifies each payer or provider entity pursuant to subdivisions (1) and (2) of this subsection, the executive director shall send a notice to each such payer or provider entity. Such notice shall be in a form and manner prescribed by the executive director, and shall disclose to each such payer or provider entity:

(A) That the executive director has identified such payer or provider entity pursuant to subdivision (1) or (2) of this subsection; and

(B) The factual basis for the executive director's identification of such payer or provider entity pursuant to subdivision (1) or (2) of this subsection.

(b) (1) For each calendar year beginning on and after January 1, 2023, if the executive director determines that the annual percentage change in total health care expenditures for the performance year exceeded the health care cost growth benchmark for such year, the executive director shall identify, not later than May first of such calendar year, any other entity that significantly contributed to exceeding such benchmark. Each identification shall be based on:

(A) The report prepared by the executive director pursuant to

subsection (b) of section 4 of this act for such calendar year;

(B) The report filed pursuant to section 38a-479ppp of the general statutes for such calendar year;

(C) The information and data reported to the office pursuant to subsection (d) of section 19a-754b of the general statutes for such calendar year;

(D) Information obtained from the all-payer claims database established under section 19a-755a of the general statutes; and

(E) Any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director shall account for costs, net of rebates and discounts, when identifying other entities pursuant to this section.

Sec. 6. (NEW) (*Effective from passage*) (a) (1) Not later than June 30, 2023, and annually thereafter, the executive director shall hold an informational public hearing to compare the growth in total health care expenditures in the performance year to the health care cost growth benchmark established pursuant to section 3 of this act for such year. Such hearing shall involve an examination of:

(A) The report most recently prepared by the executive director pursuant to subsection (b) of section 4 of this act;

(B) The expenditures of provider entities and payers, including, but not limited to, health care cost trends, primary care spending as a percentage of total medical expenses and the factors contributing to such costs and expenditures; and

(C) Any other matters that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director may require any payer or provider entity that, for the performance year, is found to be a significant contributor to

health care cost growth in the state or has failed to meet the primary care spending target, to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to reduce such payer's or entity's contribution to future state-wide health care costs and expenditures or to increase such payer's or provider entity's primary care spending as a percentage of total medical expenses.

(3) The executive director may require that any other entity that is found to be a significant contributor to health care cost growth in this state during the performance year participate in such hearing. Any other entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to reduce such other entity's contribution to future state-wide health care costs. If such other entity is a drug manufacturer, and the executive director requires that such drug manufacturer participate in such hearing with respect to a specific drug or class of drugs, such hearing may, to the extent possible, include representatives from at least one brand-name manufacturer, one generic manufacturer and one innovator company that is less than ten years old.

(4) Not later than October 15, 2023, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care spending trends in this state, including, but not limited to, trends in primary care spending as a percentage of total medical expense, and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (b) of section 4 of this act;

(C) Describe a plan for monitoring any unintended adverse consequences resulting from the adoption of cost growth benchmarks and primary care spending targets and the results of any findings from the implementation of such plan; and

(D) Disclose the executive director's recommendations, if any, concerning strategies to increase the efficiency of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

(b) (1) Not later than June 30, 2024, and annually thereafter, the executive director shall hold an informational public hearing to compare the performance of payers and provider entities in the performance year to the quality benchmarks established for such year pursuant to section 3 of this act. Such hearing shall include an examination of:

(A) The report most recently prepared by the executive director pursuant to subsection (e) of section 4 of this act; and

(B) Any other matters that the executive director, in the executive director's discretion, deems relevant for the purposes of this section.

(2) The executive director may require any payer or provider entity that failed to meet any health care quality benchmarks in this state during the performance year to participate in such hearing. Each such payer or provider entity that is required to participate in such hearing shall provide testimony on issues identified by the executive director and provide additional information on actions taken to improve such payer's or provider entity's quality benchmark performance.

(3) Not later than October 15, 2024, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of

the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care quality trends in this state and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (e) of section 4 of this act; and

(C) Disclose the executive director's recommendations, if any, concerning strategies to improve the quality of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

Sec. 7. (NEW) (*Effective from passage*) The executive director may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of section 19a-754a of the general statutes, as amended by this act, and sections 2 to 6, inclusive, of this act.

Sec. 8. (NEW) (*Effective January 1, 2023*) (a) For the purposes of this section, "health enhancement program" means a health benefit program that ensures access and removes barriers to essential, high-value clinical services.

(b) (1) Not later than January 1, 2024, each insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues in this state an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes shall develop not less than two health enhancement programs under such policy.

(2) Each health enhancement program developed pursuant to subdivision (1) of this subsection shall:

(A) Be available to each insured under the individual or group health insurance policy; and

(B) Provide to each insured under the individual or group health insurance policy incentives that are directly related to the provision of health insurance coverage, provided such insured chooses to complete certain preventive examinations and screenings recommended by the United States Preventive Services Task Force with a rating of "A" or "B".

(3) No health enhancement program developed pursuant to subdivision (1) of this subsection shall impose any penalty or other negative incentive on an insured under the individual or group health insurance policy nor shall any insured be required to participate in a health enhancement program.

(c) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall include coverage for the health enhancement programs that the insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivered, issued, renewed, amended or continued such policy developed pursuant to this section.

(d) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall include coverage for the health enhancement programs that the insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivered, issued, renewed, amended or continued such policy developed pursuant to this section.

(e) The Insurance Commissioner may adopt regulations, in

accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 9. Subsection (a) of section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) An application for a certificate of need shall be filed with the unit in accordance with the provisions of this section and any regulations adopted by the Office of Health Strategy. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee **[**of five hundred dollars**]** based on the cost of the project. The amount of the fee shall be as follows: (A) One thousand dollars for a project that will cost not greater than fifty thousand dollars; (B) two thousand dollars for a project that will cost greater than fifty thousand dollars but not greater than one hundred thousand dollars; (C) three thousand dollars for a project that will cost greater than one hundred thousand dollars but not greater than five hundred thousand dollars; (D) four thousand dollars for a project that will cost greater than five hundred thousand dollars but not greater than one million dollars; (E) five thousand dollars for a project that will cost greater than one million dollars but not greater than five million dollars; (F) eight thousand dollars for a project that will cost greater than five million dollars but not greater than ten million dollars; and (G) ten thousand dollars for a project that will cost greater than ten million dollars.

Sec. 10. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this chapter, unless the context otherwise requires:

(1) "Affiliate" means a person, entity or organization controlling, controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation organized under chapter 594b.

(2) "Applicant" means any person or health care facility that applies for a certificate of need pursuant to section 19a-639a, as amended by this act.

(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive.

(4) "Capital expenditure" means an expenditure that under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, transfer, lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure had the acquisition been by purchase.

(5) "Certificate of need" means a certificate issued by the unit.

(6) "Days" means calendar days.

(7) "Executive director" means the executive director of the Office of Health Strategy.

(8) "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

(9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of

the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

(10) "Health care facility" means (A) hospitals licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C) freestanding emergency departments; (D) outpatient surgical facilities, as defined in section 19a-493b and licensed under chapter 368v; (E) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; (F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

(11) "Nonhospital based" means located at a site other than the main campus of the hospital.

(12) "Office" means the Office of Health Strategy.

(13) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

(14) "Physician" has the same meaning as provided in section 20-13a.

(15) "Termination of services" means the cessation of any services for

a period greater than one hundred eighty days.

[(15)**]** (16) "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility, institution or large group practice, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

[(16)**]** (17) "Unit" means the Health Systems Planning Unit.

Sec. 11. Section 4-5 of the 2022 supplement to the general statutes, as amended by section 6 of public act 17-237, section 279 of public act 17-2 of the June special session, section 20 of public act 18-182, section 283 of public act 19-117 and section 254 of public act 21-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, the executive director of the Office of Health Strategy, the executive director of the Office of Military Affairs, the executive director of the Technical Education and Career System and the Chief Workforce Officer. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of

Education."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-754a
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section
Sec. 8	*January 1, 2023*	New section
Sec. 9	*from passage*	19a-639a(a)
Sec. 10	*from passage*	19a-630
Sec. 11	*July 1, 2022*	4-5